The spiritual aspect of this work has been emphasized, but I would not like to leave the impression that I think we should talk of these things with all our patients. This is pre-eminently the work of the hospital chaplain, but as the Archbishop of Canterbury has recently written, When it comes to dying there is no distinction between doctor and chaplain—both are pastors and the faith of the doctor can often do far more than that of the chaplain, just because the doctor has been fighting the battle of life and death with the patient day by day more intimately than can often be the case for the chaplain. Much of our help is the contagion of our own experience and trust, but patients may ask for something more explicit from those they know well.

I have written as a member of the Church of England, but would ask for more instruction about these problems from all who can help us. Valuable teaching is now given to many nurses by their hospital chaplains, but we still need more discussion and co-operation between them, the doctors in charge and all the staff in contact with these patients.

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Reprint published by Macmillan and Company Limited
St. Martin's Street, London, W.C.2. Price 2s. 0d.

The Problem of Euthanasia

THE SUBJECT OF EUTHANASIA or 'mercy killing' has recently been discussed in the daily papers and many nurses must have been made to consider their own views on this controversial subject. They of course, are not in any danger of having to decide on the right course of action in any particular case but they must be nearer to many patients than those who write and talk about them and should therefore be able to give considered and valuable opinions on the subject.

It appears to me that there are two sides of this problem to be considered. Is euthanasia morally right? And is there really no other way of relieving the distress of patients in the terminal stages of cancer?

The members of the society which is campaigning for an alteration in the law of Great Britain contend that euthanasia is in accordance with both humanitarian and Christian concern for distress but they are not able to produce any statistics of the proportion of these patients who suffer intractable pain, nor the number who do, in fact, ask for such release.

Not our Responsibility

Most of us can undoubtedly recall patients whose death we would like to have seen hastened but it is my belief that if we had taken such action we would have assumed a responsibility which is not ours. I believe also that this question can only be helpfully considered from the Christian point of view and that we are faced here with the problem of pain and must look at it as a whole.

Many things we see are hard to reconcile with our faith in a loving and omnipotent God. There is no complete and easy explanation but we can see some clues to the full answer which we will only find in eternity. *These are enough to give us confidence and to show us* what we have to do in practice.

God gave freedom of will and action to man and

is by his own misuse of this freedom that death and all that leads to it has been brought upon him. I do not mean by this that every illness is caused by the individual's wrongdoing but that disease and all our other ills were caused in the first instance by the sin of man. These things are permitted by God because He can use them to serve His own purposes and bring about an even greater good in the end. Our salvation came through the suffering and death of Jesus Christ and our own trials can be made the means of our discipline and transformation into His image. I have seen this begin to happen many times during a terminal illness, but there still remain a few who seemed overwhelmed by their distress and for whom one can only be glad that it is now over. As we think of these patients we are left to trust where we do not understand.

The fullest consideration of the problem of innocent suffering in the Bible is given in the book of Job. Job was not given any answer to his questions but instead was shown a vision of God which silenced his asking. We are given the vision of Jesus Christ crucified, "bearing away the sin of the world" and 'bearing our griefs and carrying our sorrows'. That vision can bring us to the point where we too stop asking.

Some rationalists argue from this that if we think that suffering has such value we are illogical to try to relieve any of it. As Christians we can give the simple answer that we were told to do so by Our Lord Himself. We can also add that although sufferers themselves are told to accept and therefore transform their trials they are not told to go and seek them out for themselves. We are told on the one hand that God "doth not afflict willingly nor grieve the children of men" and on the other "it is for discipline that we have to endure". We can safely leave the paradox to Him for our duty is clear enough. We are to relieve the trials of others where we can and to accept our own when they come to us, offering them up to Him in the strength of Christ's sacrifice.

Facing the Truth as a Family

Terminal illness accepted in this way can bring about great victories. A man became certain of his diagnosis but said nothing until he decided that the time had come for the truth to be faced as a family He made his most unwilling doctor confirm his suspicions after he had already met and overcome his own fears. His family were as relieved as he to come to the end of their deception. He set himself to make the end bearable, even joyful for them. He remained confident in his rarely expressed, but very real, Christian faith, he settled his affairs in detail and planned his own funeral and many mundane matters with great humour and wit and kind understanding of those he was leaving He discussed his family's hard work in caring for him and whether he should go into hospital, and other problems, with his doctor and continually astonished him by his realistic and even Rabelaisian attitude to the processes of illness. He endured a fair amount of pain without self-pity he remained clear-headed and fairly active on tablets of codeine compound, brandy and small doses of morphine until his last two days and was unconscious for several hours before he died. The good hours were the best of the family's good life together the bad ones are remembered by them with pride. His last illness brought out the best that was in this man and perfectly completed his life.

Finding Reconciliation and Peace

There are others who seem overwhelmed and defeated as they approach death but I do not believe that we should step in to spare them the suffering we hate to see, for we are not in a position to know what a dying man may find of reconciliation and peace in his last days. I remember one lonely young man who seemed to have passed in bitterness into a distressed semi-conscious condition and looked as though he were in great need of a merciful release Instead he regained

consciousness, and in his last two weeks suddenly responded to the help that had been offered him before and became reconciled to the God whom he had ignored all his life. His calm was as obvious as his former misery Such a memory will prevent us from wanting to deny anyone such an opportunity I can quote no figures but I have seen several patients who seemed only just ready when the end finally came, and many others who have continued to grow in patience and courage right up to their last moments. It is not only those who start with a personal faith who prove that God's grace is sufficient for every need, for many come to find this for the first time in such an illness.

It is not only those who express their faith who are transformed, nor indeed, only those who know that they are dying In my experience resentment, bitterness and difficulty are very much the exception among both patients and their relations.

Mr C. had a total gastrectomy for a carcinoma of stomach in August 1956. Two-and a half years later he was admitted to a terminal home. He had never been well enough to return to work and for the past weeks had been afflicted with increasing dysphagia and vomiting. On admission he was miserable and emaciated. We could not stop his vomiting and he was not easy to satisfy in any way He complained of the medical and nursing treatment, was difficult with his family and after 12 days insisted on taking his discharge. At the request of his daughters, who said that he had never been easy I told him the truth about his condition and warned him that he could not be cared for adequately at home. Saying It's all right, doctor, I shan't go over the bridge but I've made up my mind and my family must just manage he went home. Five weeks later he returned to us, a completely different man.

I saw him on admission and he said at once 'I was wrong My son had to leave work to look after me and they just couldn't do it. I shall settle now He was immensely grateful to his children for all they had tried to do to help him have his own way and to the home

for having him back. He showed glimpses of his former cantankerous self now and again but he went on becoming a more patient and a nicer man until he died about two weeks later. It was my impression that he had never shown such humility and unselfishness in his life and we admired him greatly for achieving it when he was in such illness and distress. It seems to me, however that only this suffering had been able to bring him to the place where he was able to do such a thing. It had brought out the very best that was in him, and I believe the very fact that it had done this showed that he was not far from the kingdom of God although he never made any mention of spiritual things.

Some of the protagonists of euthanasia will not be moved by these arguments for these transcendental values have no reality for them. For them remains the second answer that it can and should be unnecessary.

It is my experience in two terminal homes that we can relieve the suffering of 90 per cent. of the patients and bring it within their diminishing compass where we cannot relieve it entirely. The remaining 10 per cent. suffer from intractable vomiting, dysphagia and dyspnoea more often than pain, and in one or two mental distress has been predominant. We occasionally sedate these patients heavily but have never had to give doses of narcotics which would be fatal in themselves. We are continually trying new ways of helping them and where we fail we try to make them feel that we are truly sharing it with them as far as we can.

This is not to deny that patients do suffer in this country but to claim that the great majority need not do so. Those of us who think that euthanasia is wrong have the right to say so but also the responsibility to help to bring this relief of suffering about. This aspect of the problem will be dealt with in greater detail in further articles in this series. They will be written from the point of view of those working in hospital and in terminal homes because that is my own experience. For many patients the ideal is that they should stay at home

and be cared for by their relations, by the district nurses and by their own family doctors and I hope that most of the suggestions given will be relevant to that situation as well.

Should a patient know ...?

SHOULD A PATIENT know he is dying? This question is argued freely by nurses and doctors and also by his friends and relations. It is wrong to be dogmatic in advancing one's own views and it is impossible to suggest a general rule, but we do need to consider some basic principles on the subject if we are not to be caught unawares and to make decisions based on little more than our feelings.

A woman of 44 had a baby after the rest of her family had grown up. She had a great deal of indigestion during her pregnancy and afterwards, but was not X-rayed till her baby was over a year old. She was found at laparotomy to have an inoperable carcinoma of stomach. She was admitted to a terminal care home three months later. At this time she had lost about 5 stone in weight, she could not keep anything down and was dehydrated, and she had 'aches and pains all over'. She was given injections of Omnopon, gr ⅓ with chlorpromazine 25 mg, four times a day, and a continuous rectal infusion of tapwater. She could only take sips of iced water by mouth. She responded well at first, was alert and co-operative and delighted to be relieved of her pain and to be a little less thirsty.

Acceptance and Peace

A fortnight after her admission her condition deteriorated further: she became unsettled and homesick and began to question our treatment. Realizing that she needed to talk, an opportunity was made to examine her slowly alone. During this session the first discovery

was that the precipitating cause of her unhappiness was the brusqueness of the night nurse, but after we had discussed this she began to ask questions and gradually her deeper troubles were revealed. She finally demanded to be told the truth about both diagnosis and prognosis. Her immediate reaction to the truth was gratitude. "I ve asked again and again and no one would tell me. I think it's so wrong not to be told if you want to know She took it with great calm and seemed to respond to the mention of spiritual things, but did not want to see the chaplain.

She became much more peaceful but longed so much for home that the ward sister a nun, became convinced that there was something she badly wanted to do there. In her turn she sat down to talk with the patient who by now was very weak but still completely alert. She discovered eventually that the patient wanted to join the Roman Catholic Church and thought she would have to go home to do so. The priest was called imme diately and she was received the day before she died. The rest of her family all rather lapsed members of this Church, were greatly challenged by this action and by her acceptance and peace.

We see here how essential it is to talk to a patient alone and to help her bring her fears to the surface gradually We see how the lies which are intended to shield from fear may in fact add to distress, and that a patient must be allowed to take the initiative because she may well know her real need much better than we do. We see that the problem may not be solved by one person alone but by several who, while keeping the patient s confidence, may yet help each other to make their individual contribution.

We may add in parenthesis that many patients will take their discharge rather than complain about any individual The nurse in question here had caused much other unhappiness but none of it was discovered except by direct questioning. This episode led to her leaving that hospital.

Once this patient knew the truth she was able to find peace and comfort, and one feels that her last few days will influence her family greatly for good. She took the initiative in demanding frankness, but this is not always the case. Some people almost deliberately choose not to know and they too, have a right to their choice and to our co-operation in it. We may practise a conscious mutual deception with them or they may do this unconsciously In such cases unwelcome and premature information can create havoc both in the patient and his relatives. It is here we see the despair the pathetic search for new doctors and new cures, the self pity and disintegration that is quoted by those who say 'No good ever comes of telling the truth in these cases"

Relatives vary as patients do in their desire for the truth and many ask that the patient should not be told and prefer to try to keep up normal relationships. Some do this successfully to the end. Others may need to be restrained from over acting or helped to see when the patient really wants to be honest with them. One patient was greatly distressed because as she gradually realized she was dying her husband remained apparently cheerful and oblivious. He was told what was happening and was able at last to show her how much he cared.

It is difficult to know what another man thinks and needs. The final responsibility for deciding lies with the doctor but so often we seem to fail, everyone leaving it to everyone else. In hospital it usually rests between the houseman and the ward sister and they may receive a more or less definite lead from the consultant. The ward sister often knows the patient and his needs best, but feels it is not her job the houseman is inexperienced and is often perplexed by the whole situation, and perhaps it is the nurse doing the blanket bath who gets the direct question. It is certainly not her responsibility and she must pass this question on to someone more senior Even so she may be nearest to the patient in his distress and able not only to help him as he faces it but

also the others as they try to understand him.

Truth is not in Words

It is not right in principle to set out deliberately to deceive and truth must not be lightly disposed of in any situation. I do not, however think it is essential for every patient to know he is dying, and the most important principle is love, which is not sentimentality but compassion and understanding. Those who establish close contact with their patients will best be able to decide whether they want or need to be enlightened and will approach as friends with courtesy and kindness. In this setting those who want to know can accept the truth and find the strength to face it.

In my own experience I find that the truth dawns gradually on many, even most, of the dying even when they do not ask and are not told. They accept it quietly and often gratefully but some may not wish to discuss it and we must respect their reticence. Others take the initiative and ask at an earlier stage—but they will not ask unless they believe they will receive a considered and kindly answer. If they do ask I believe they should be told. I think it is rarely right for us to take the initiative and even when we are asked we must sometimes hedge and prevaricate where we judge the patient to be unready as yet to face the full knowledge. I do not pretend that it is ever easy either to decide or to carry out our decision nor that we will not have regrets.

Another Hope

It is rightly said that one should not take all hope of recovery away and leave anyone alone without light. Those most willing to tell the truth are those who believe that there is another hope for their patients and that they can be helped to look reality in the face with hope and courage.

There is not much teaching in the Church of Engl

about death and preparation for it. There is much ignorance of what Christianity is really about among the majority of the population, but some hope of an existence after death is almost universal. Whatever the doctor's personal views about the possibility of life after death, he should act in the presence of a dying man as if he believed in it (Craddock). If the doctor or nurse can do more than act and can speak naturally and with real faith of the mercy of God in Christ and the place "where there shall be no more death, neither sorrow nor crying, neither shall there be any more pain" she will often find an eager response. This may be an eleventh hour response but in the parable of the Labourers in the Vineyard in St. Matthew's Gospel, Chapter 20, those who were hired at the eleventh hour earned the same reward as those "who had borne the burden and the heat of the day." Much of this help is best offered indirectly and in a way that makes it easy for the unwilling patient to refuse it. Harm may be done by unwelcome discussion.

The care of the dying is pre-eminently the time for doctor, nurse and chaplain to co-operate. In practice at the moment many people are so out of touch with the Church that they find it hard to respond to the visit of a clergyman at this stage. Moreover, as Worcester points out "The dying do not always recognize the difference between the clerical and medical professions and are also unable to distinguish between the need of physical relief and that of consolation."

Doctors and nurses who have time and heart to listen will have all types of problems, mental, moral and spiritual, brought to them. They will refer their patients to a clergyman where possible but it is important that he should not just be called in at the last moment. In many hospitals the chaplain's visit is a routine but it is a great help to him if he is told as soon as possible of anyone who is in special need. While we are waiting for the opportunity to call in someone else we have a responsibility to do the best we can for the people who turn to us, for it may be that someone who

has been helping the patient with his physical needs has the key to his confidence and the first opening to help him in this way

Control of Pain in Terminal Cancer

AT THE AGE of 54 Mrs. W was found to have a fairly advanced carcinoma of cervix and during the next nine months she had three courses of radium. Finally after a further three months of increasing ill ness at home, she was admitted to a terminal care hospital.

When she was admitted her husband informed us that he had told her her diagnosis because he believed that it was right for her to know She had been dragging herself round at home with considerable pain which she described as being 'black with pain at times She had had only mild analgesics and sedatives and admitted that she often took the latter by day to get through the time She was frightened of hospital and of death and was very tense and tearful on arrival. She was obviously in pain. She had a fungating secondary growth invading her vulva and very severe dysuria. She was intelligent and was co-operative from the start.

Revealing her Fears

A local anaesthetic ointment was applied to the vulval growth, and she was given a sulphonamide for a urinary infection Mist. aspirin gr 10 with Nepenthe 30 minims four times a day controlled her pain She settled down quickly and a few days after her admission she revealed some of her fears. She associated her illness with her sins of the past and though very anxious to pray felt cut off by her guilt. She probably confided in the doctor because to her it was partly a medical problem and because we were alone and in no hurry I tried to help and she seemed comforted but with her permission I told the nun in charge something of our [illegible]

and asked her to tell the chaplain.

After this Mrs. W's peace and acceptance never failed to the end and compelled admiration from us all.

After her first three weeks she told us that she had had "more ease than during the whole 15 months of illness". By this time, however, she began to show signs of sciatic nerve involvement and her dysuria became more severe. She was sleeping well on an injection of Omnopon, gr ⅓ at night, and as the early morning was her worst time this dose was also given as routine as soon as she woke. The mist. aspirin and Nepenthe continued as before. At this time the vulval growth began to occlude her urethra and after one episode of retention and pain a self retaining catheter was inserted under local anaesthesia. This was not without its problems but was inevitable.

The Omnopon was increased to gr ⅓ but at this time she complained that it made her feel 'dopey'. Both Omnopon and the mixture were stopped and instead she was given injections of morphine, gr ¼ with amiphenazole, 50 mg. four times a day at routine times. The addition of the latter drug helped to overcome the narcotic effect and she noticed the difference as soon as it was added. The combination controlled her pain although her catheter caused distress more than once.

Seven weeks after her admission Mrs. W's condition began to deteriorate rapidly and she developed pneumonia. The morphine was continued without amiphenazole. She gradually became more drowsy over the next few days and died after several hours' complete unconsciousness.

Analgesics are not the only means we have of relieving pain and much of Mrs. W's distress was relieved by the confidence she had in the skill of the staff. We sometimes find that local heat or other applications, the giv- of antacids, attention to the bowels and all the other nursing treatments which are discussed later will help really severe pain. It is also worth giving a course of an antibiotic in some cases. Nor must it be forgotten that Mrs. W needed help and understanding in her mental and spiritual worries and that this was her greatest dis-

tress when she was first admitted. These must never be omitted—but there are still many patients who rely on us for a careful use of the great variety of specific analgesics to relieve their pain.

This is, of course, the doctor's province but a nurse is often left with a good deal of discretion in giving the drugs prescribed and it is her responsibility to watch the patient and judge their effects. It is also true that house men are often very inexperienced in this field and will ask advice, and sometimes take it.

Mrs. W was in continuous, severe pain when she was admitted and she was given drugs regularly from the start. It is my opinion that this is the cardinal rule in the treatment of pain in this type of patient. Pain should never be allowed to take control and regular doses of analgesics should be given as soon as a patient is at all worried by it. It is not safe to rely on patients to ask, for either they will wait too long (and once pain has become really severe it is a potent antagonist to any drug) or else they will ask too soon and addiction may become a problem. If a patient receives prompt relief from the beginning and knows that he can rely on the next dose appearing on time he does not increase his own pain by fear and tension. There must, of course, be some latitude and no one should be kept in pain until the right time (Sometimes a milder analgesic by mouth in between injections is enough.)

We should begin with drugs by mouth when possible and mild and moderate pain is often surprisingly well controlled by aspirin or tablets of codein compound. A most effective mixture is made by dissolving these with 15-30 minims of Nepenthe.

Pethidine is unreliable by mouth and its action by injection is only of two to three hours duration. Levorphanol and methadone are both rather capricious in their action and the latter often causes vomiting and nightmares. All these drugs, however suit some patients and are worth trying at times. New analgesics are continually being introduced and it is most difficult to k-

up with them, but those who look after large numbers of patients with terminal cancer say they always return to the opiates. They are given for distress as well as for pain and they are unrivalled when used properly and with confidence.

Regular small doses are started by mouth if possible, either as Nepenthe or liquor morphini aspirin alcohol or cocaine may be added and the mixtures given regularly from twice daily up to four hourly Injections are given for more severe pain and are more reliable. It is my opinion that there is little to choose between morphine and Omnopon in equivalent doses and that diamorphine is really needed for persistent painful coughing and for some patients who vomit after all the other opiates.

Tolerance to Drugs

Tolerance develops very rarely indeed if these drugs are *given regularly* *Very rarely indeed do we give* more than one grain of morphine or its equivalent and most patients need much less. The doses remain effective for months, and sometimes for years. I know one old lady who has just died after over three years in a terminal hospital. Nearly her whole face was eroded by an epithelioma but she was alert and not unhappy She had morphine effectively for most of this time. She had worked up very slowly to morphine, gr I four hourly, but this was gradually reduced until for some weeks *before she died she was perfectly comfortable on* nothing at all. During her last two or three days she had gr ¼ once more and this was enough to give relief.

Addiction, the continual craving for injections, hardly ever occurs and we are finding that the rare patient who develops it responds almost immediately when amiphenazole is added. I cannot emphasize too strongly that rapidly increasing the dose of an opiate is not the best nor the kindest way of dealing with intractable pain. It so often demoralizes the patient and may indeed increase his anxiety and mental

distress. We do him a great and unnecessary disservice when we thus take away his dignity and his ability to face up to his illness and watching him may be a terrible experience for those who love him.

Side-effects, though far less with these small doses, can still be troublesome. The danger of constipation calls for constant vigilance, for prevention is better than cure. Nausea and vomiting occur more often in women than men, but tend to subside spontaneously and almost always respond to anti-emetics. Heavy narcosis is rare and personality changes absent with these dosages. Excitement occurs very occasionally respiratory depression is no problem. Lack of ability to concentrate on reading troubles some people.

Much of our total pain experience is composed of our mental reaction and so most of these patients need some sedative. The opiates in themselves may be enough, but this is by no means inevitable as their action is variable. Most patients benefit from a mild sedative by day and alcohol may be most beneficial. One grain of phenobarbitone in the evening as well as the late night dose of a hypnotic will almost always give a good night. If a patient is helped to relax his need for analgesics lessens correspondingly The sedative effect of chlorpromazine and similar drugs is as useful as their anti-emetic action.

Our Confidence

Most patients think that cancer and death are inevitably painful. Mrs. W was waiting for the pain to overwhelm her when we told her that it would instead fade away before she died. Any who know their diagnosis should be reassured on this point. Our reassurance and confidence in our own methods will do more than anything else to make it true that the pain of terminal cancer can be controlled in almost every patient.

Mental Distress in the Dying

Miss R. was admitted for terminal care when she was 54 years old. She had a carcinoma of breast which had been beyond all treatment when she was first seen and she had metastases in both lungs and in her liver. She had come originally from East Prussia, had fled to Berlin after the war and then to England a few years previously, leaving her mother and sister in Berlin. She had never been married and since coming to England had worked as a housekeeper. Her English was fairly good and she was an interesting woman, very good looking, gentle and intelligent, but she was a very isolated and withdrawn person with whom it was hard to make real contact.

A Patient Difficult to Help

She had some pain but her main complaint was of a feeling of tightness in her chest and of suffocation. Her mental suffering was all too apparent. She was extremely difficult to help and comfort because her whole experience and personality made such an illness and the publicity of a general ward wellnigh intolerable to her. The nursing staff found her difficult to handle and she found them hard to understand. She had a habit of wandering about the ward at night and shutting herself in the bathroom with the window open which was a continual worry but yet had to be allowed as it so *obviously was a relief to her*. She continually refused medicines as she disliked anything that made her feel sleepy and she often suffered from nausea. She was frightened of injections and bruised easily. She alternately felt that we were doing nothing or that we were making her worse by what we gave her. She had no idea of her condition and clutched so hard at any sign of improvement that it seemed wrong to be frank with her. She refused the offer of a visit from a German pastor or welfare worker.

Some confidence was gradually established and finally when I was examining her one day and in

answer to a direct question, I told her that she had good reason to feel anxious and that she was indeed seriously ill. At this she burst into tears and wept on my shoulder but after an outburst of rather unintelligible complaints about English doctors she became much more calm. Neither then nor later did I tell her that she was dying and she never realized nor accepted this possibility At this stage she agreed to see a German friend of mine, a trained mental nurse who gave up her next day off to come. She was an immensely sympathetic listener and this visit was of very great value. She helped us to understand a little more of Miss R s character and personality finding her a most lonely person who had deliberately come over to England on her own and who had no desire even now to return to her own land and family She had a great love of beauty and perfec tion but she had always sought these things in art and music and not in personal relationships. She did not want to die and was convinced that she ought to get better

After this visit Miss R s condition deteriorated rapidly and when my friend called the next week she found her very weak and ill. She stayed with her all the afternoon and evening and Miss R. asked her to write to her relations and to deal with all her affairs, although she did not realize even then that she was dying She did talk over many of her fears and troubles, however and my friend was able to offer her not only understanding and sympathy but also some spiritual help. Miss R. seemed comforted and peaceful at last. After a restless night she became unconscious and died next day

Because of her request we were able to arrange a Lutheran funeral and to collect all her belongings and to send them to her relations through the German Embassy There was no one to attend but ourselves and a German deaconess who had known her but with whom she had not tried to make any contact once she had become ill. Miss R. never had any visitors during the whole five weeks she was with us and had no friends at all in England.

Understanding by a Stranger

Miss R. had lived a withdrawn, solitary life and was inevitably lonely in her death. I blame myself now for failing to arrange a visitor before, but perhaps she could only accept love and understanding of that kind from a stranger and when weakness had broken down some of the barriers she had erected around herself. We will never know whether she had always been like that or whether she had been badly hurt in the past and become isolated in fear of further pain. Perhaps some may feel that we should not have even tried to penetrate these barriers but I think it was a very fortunate chance that there was someone to grasp her hand when she was at last able to hold it out for help I am quite certain that she was deeply comforted and that the long letters written to the relations meant a very great deal to them.

Most patients do not present such problems as Miss R. but it is always hard to understand another person's mind. We must make some attempt, however as mental distress may be the greatest suffering that our dying patients have to endure on their *via dolorosa*.

We all have an instinctive belief in our own survival and most patients at least begin as optimists with considerable faith that their doctors can and will cure them. Increasing illness gradually undermines this confidence and anxiety and fear very often take its place. Patients lie in bed afraid of what may be the matter with them of pain and of yet another treatment or operation they worry about what is happening or will happen to their relations, many begin to think of death and to fear it, and I often find people who are even more afraid of a chronic illness or that they will not be able to go on acquitting themselves as they would like. Some find it hard to express their fears even to themselves and seem lost in apprehension and bewilderment.

There is a widespread faith in the progress of medicine which makes it hard for some patients to believe that there may be no cure for them When they find

that they are not improving they feel unsatisfied with what is being done for them and become filled with resentment. This may be directed against the hospital, the doctors and the nursing staff or against their families. It may be expressed openly or be shown in demanding suspicious or querulous behaviour. Some patients become frankly paranoid. Previous experience or their own personalities may make the regressive and dependent situation of being a bedridden patient very hard for some to bear. The active and athletic find increasing weakness intolerable and many men simply do not know what to do with themselves. The intelligent and alert find the contraction of attention that comes with weakness equally hard to bear. Some patients feel obscurely that it is all their own fault, or they may have definite feelings of guilt for some episode of their past. Depression attacks many especially those who suffer a slow decline.

Harmful False Hopes

It is right that patients should begin their active treatment determined to live and to co-operate and fight with all they have in them, but there comes a time for many when the sick body and tired mind can do no more. This comes hardest to those who have been encouraged with false hopes for too long or who have been told that it depends on them and that they must go on fighting. Well-meaning relations sometimes do more harm than good by over-encouragement. Many people find that it is easier to look after the dying when they still have hopes of recovery. This is indeed so for some and for a good part of their illness for others, but it is not so with all and I have seen acceptance of the inevitable lead many times to great peace and mental and spiritual gain.

Patients are all too often treated as unquestioning and unintelligent. We do not realize how many are suspicious and often underestimate their anxiety and that of their relations. It is a revelation to visit a friend the night before an operation that seems trivial to

or to be one of a family involved in this whole situation. I would add here that we can do much harm by isolating a patient from his family when he comes into hospital He is still part of it and it is hard for the relations if they do not know what is going on.

Fear plays a great part in the life of a patient in hospital and in that of a sick person at home It is my opinion that for many fear of the unknown is harder to bear than fear of the known. Perhaps death is the worst unknown of all, but yet once it has been faced and accepted it does not seem so terrifying as the other possibilities that loom up in front of the patient who is kept continually in the dark about what is happening to him. Several times recently patients have said to me that it was not death they were fearing, but chronic illness or pain or going on indefinitely in their present condition. It seems to me that it is very important to try to understand the fear that our patient is actually facing so that we can help him to tackle it. Sometimes relations are very helpful here but others either do not themselves understand, or are so involved with their own sorrow that they cannot be objective enough. Miss R. is not unique in being able to talk to a stranger when she could not come close to her own family

Mental Pain

We can and must help our patients mental pain as well as their physical pain. Much can be done by calm, dependable nursing but it is the real listener who helps most of all. The nurse often has the greatest opportunity to fill this role and can therefore give her patient his greatest solace.

It is necessary and right to use drugs sometimes to help mental distress. The opiates are unrivalled and must not be withheld just because there is no physical pain. A small dose of Nepenthe by mouth may be sufficient. The tranquillisers are not as a rule effective with these patients for more than a few days and chloral and the barbiturates remain the most reliable seda

tives for the anxious patient. Hyoscine adds greatly to the sedative effect of morphine but it may excite some patients. Its effect on the elderly is very unpredictable but it is the best drug for terminal mental disturbance. Sometimes one injection with morphine will be enough for several days, at other times it may have to be given regularly Chlorpromazine and the allied drugs are valuable and are widely used but some people object to them because they make them feel doped. They are very useful with the elderly patient who becomes disturbed and unco-operative.

Alcohol can be used with great benefit. Whisky and brandy in the evening hot drink help the elderly to sleep and are given with effect when patients are suddenly overcome with that weariness and feeling of disintegration that is often worse than pain. Sherry may still act as an aperitif and beer and stout are good for those who are accustomed to them. I know some patients who take little else and I remember one who used to visit the local pub daily from his terminal hospital and really enjoyed pouring stout into his gastrostomy Another old man in hospital had a splendid time with nothing but a bottle of port over Christmas ("a real old-fashioned Christmas, Sister") and died two days later Some of these drinks can be supplied in hospital but they may also be welcome presents from friends and relations when there is little else that they can bring

Effective stimulants are hard to find. Cocaine is the best but some form of interest and activity may act just as well and may be maintained until the end or near it. I remember one man who was backing horses with his National Assistance Board money and giving the matron of his nursing home bad tips up till his last day and several women who were knitting for their daughters for nearly as long.

Faith in Someone

Here more than anywhere else it matters that "we give ourselves with our pills" (Worcester) Suffering

is only intolerable when nobody cares and one continually sees that faith in God and His care is made infinitely easier by faith in someone who has shown kindness and sympathy

Man's first reactions to his trials tend to be rebellion but again and again one sees this pass and be replaced by acceptance and a deeper awareness of spiritual realities. Early in this century a regular visitor at St. Luke's wrote "It is what the process of dying does to people that is so beautiful and unexpected I think the spirit of calm trustfulness and resignation to be met with in the wards is principally the patients own. I never cease to wonder at the qualities they evolve, the attitude they assume towards the end" I see the same thing happen continually today Perhaps fewer know that they are dying than knew at that time, but whether they know or not, pain and suffering, where they are not allowed to overwhelm the patient, and when he is in a place where he is made to feel welcomed and loved, almost invariably bring out the best in him It is a privilege to see this happening

The Nursing of Patients Dying of Cancer

It is fortunately impossible to quote an individual patient whose story illustrates all the various nursing problems that have to be solved if those dying of cancer are to be kept comfortable to the end. Their trials and discomforts are varied and much of the nursing is the same as that needed by any other ill patient. There are, however some problems which loom particularly large and some nursing techniques which are helpful in dealing with them The following suggestions are culled from several sisters who have cared for these patients for years and from my own observations in terminal homes.

Intractable vomiting is the greatest misery and it can make a nurse feel more helpless and desperate than

anything else that affects these patients. Some cases are due to the growth itself and are caused by bleeding or mechanical obstruction others are due to the drugs being given and I am convinced that some have a psychological element.

Opiates do not cause vomiting so frequently when the patient is in pain and in bed as they do in normal people, but are undoubtedly responsible for some cases. Anti-emetics may be sufficient, or the tendency may wear off after a few doses. It is worth while trying different drugs in this group and I find that diamorphine is the least likely to cause this trouble It is also worth using several anti-emetics to find the one which suits the individual patient best. These may have to be given by injection or as suppositories, but the antihistamine group of drugs have a local as well as a central effect and are sometimes better when given by mouth.

Some patients respond amazingly well to reassurance, a careful diet and antacids. Others who cannot tolerate any food will be able to take soda water or iced water I had one patient who ate endless iced lollies and little else. Others respond well to sedatives, and some, rather surprisingly to the opiates themselves. They have probably been vomiting because of pain and misery

Little can be done if the cause is really mechanical, for the time for any form of surgical intervention is past. It may be worth passing a nasal tube and instituting intermittent or continuous suction to prevent the constant retching and supplementing the fluid intake with a rectal infusion.

Dysphagia may be so severe that anything taken by mouth will cause vomiting and a spill over into the lungs. Local anaesthetics in gel form before any attempt at a meal may help and iced water seems to be the most welcome drink. Occasionally semi-solids go down best. If a patient has had a Souttar's tube passed and this blocks up a drink of ginger beer may clear it. These patients need their favourite mouthwash per

Fungating growths need not be offensive. Liquid paraffin is the best known and eusol 1 : 4 may be added if there is any sepsis. The nurses find that asepsis is not necessary—scrupulous cleanliness is sufficient. It is impossible to be quite so gentle when using forceps and for an exquisitely tender area it is kinder to abandon them. Old linen is often more comfortable for the patient than gauze particularly in the perineal area.

The mouth may be involved in the primary growth and much pain can be avoided if it is kept really clean with frequent rinsing or syringing and any sepsis is treated with antiseptic paints or lozenges such as Dequadin or Hibitane. Local anaesthetic sprays or emulsions may be given before meals, but a patient may need a permanent nasal tube.

Bland mouthwashes and tablets of nicotinamide will cure many sore tongues. Pineapple and acid sweets to suck will prevent dryness but may not be tolerated. Monilia often attacks these patients but clears quickly if treated with Dequadin or Nystatin. Lipsalve or glycerine and borax are best for dry cracked lips.

Pathological Fractures. Some give no symptom while others are excruciatingly painful. They must be immobilised and this usually reduces the pain quickly. Some even unite.

Fits may be caused by cerebral secondaries and may call for paraldehyde for initial control. Regular phenobarbitone and/or chlorpromazine are best thereafter. The headache and vomiting of raised intracranial pressure may sometimes be relieved by magnesium sulphate enemas, diuretics or saline purgative if the patient is not already dehydrated.

Urinary Complications. Retention may call for an indwelling catheter Patients with fistulae remain heavy nursing problems. Some wards use rubber bedpans and can keep the patients comfortable and their backs intact others prefer some form of napkin. Silicone or local anaesthetic ointment will help to preserve the skin from excoriation. These patients often feel humiliated and need a great deal of reassurance and sympathy they often need to be told that we do not mind dealing with these things. Infections should be treated with sulphonamides or antibiotics.

Bowels are an everlasting source of interest and worry to fairly fit patients and may make life intolerable to the very ill. Impacted faeces must be removed olive oil and water enemas or suppositories may be needed and are less exhausting than strong purgatives, but if patients can be persuaded to take regular paraffin or emulsion these may be avoided. There are many aperients and both nurses and patients have their favourites which work best for them. A good fluid intake is a great help. Patients regard a regular action as their birthright and will wear themselves out over it but some can be persuaded that once or twice weekly may be quite in order for them.

Sleep. The ritual of hot water bottles, hot drinks, a well-timed bedpan, the change of position and a firm settling down, real quiet and properly shaded lights, all help to give a good night's sleep. An important factor with many patients is the knowledge that they will not disturb a tired relative if they want anything but instead a nurse who may have time to talk if she is wanted.

Sedatives are frequently needed with the evening analgesics. Opiates should not be used for sedation only and a sedative may be effectively added to them when they are needed for pain. If patients are apt to wake during the night they may be allowed to have a second dose of analgesic or sedative and in some places this is left beside them. This does mean they have every

chance of going to sleep again without delay

Long-acting drugs, particularly sodium amytal often give hangovers and may make the elderly very restless. They are safer with chloral or the glutarimide derivatives (Doriden) Alcohol works splendidly with some patients and ½-1 grain of phenobarbitone earlier in the evening will add immensely to the effect of the last sedative.

Patients vary in their response and the doses they need and it is a matter for individual assessment.

We frequently meet patients who lie still with their eyes shut all night and then complain to the day staff of a sleepless night Many of them are really awake although they do not look it and in the case of dying patients I think we should believe them and try some thing else to help them.

Bedsores can be cured even at this stage but are far better prevented. They may well give more pain than the cause of the illness and it is not an easy pain to control. Most nurses have their favourite applications and regular care is the first necessity It is worth remembering, however that many of these patients have very dry skins and may need ointment rather than spirit to preserve the surface intact.

Patients should be encouraged to get up as long as possible provided it does not add to their pain. Once they are bedridden they must be moved gently and frequently The change of position helps more than the vigorous rubbing of already precarious and ischaemic skin.

They may be allowed some independence about washing They vary tremendously in their toilet needs and apart from backs, mouths and eyes may be given some freedom in the matter Said one old man on admission 'You won t wash me will you, they washed me to death in the last place "

Hiccoughs occur for many reasons and are irritating and exhausting If carbon dioxide is not available it is

When a Patient is Dying

It is not so much death itself as the actual process of dying that most men fear—but the reality when it comes is almost always painless and peaceful. Mental and physical pain usually recede during the few days before death and almost always in the last hours.

Patients and their relations often need to be told this A man said recently to me Doctor I am comfortable now and I am not frightened to die but I am waiting for the pain to begin' He accepted my promise that it would be easy and he died in his sleep a few days later He said to me the previous afternoon "You were right, doctor I didn t have any pain" Neither he nor Mr B whose story follows, had been told that they were dying as far as I know They realized the truth gradually and the fear of death faded away as they finally approached it.

Mr B went to hospital with a fairly advanced rodent ul r of his face when he was in his late forties. Between 1938 and 1958 he had numerous courses of radiotherapy and diathermy excisions. He continued at work for the first years and then his wife looked after him at home with the help of the district nurses till only a few months before his death.

Confidence Gained

He was finally transferred to a terminal care home direct from his treatment hospital. At that time nearly his whole face had been eroded, he had been blind for some time and was also very deaf but he was alert and surprisingly good at feeding himself and at making himself understood. He had fairly severe headaches and pain in his face but this was well controlled with regularly given doses of what he called his weedkiller' a mixture containing tincture of opium 30 minims, and aspirin (He had been taking this mixture with effect for some years.) His extensive wound was fairly clean.

At first he was rather homesick for his original hospital but he soon gained confidence and settled down.

He was a gentle and affectionate old man and rarely complained. I saw his wife soon after he came in to make certain that she was really happy about his treatment. She, too, took a little while to get used to us but became very friendly. Early on in our acquaintance she mentioned her trust that God would comfort him. Her faith was based very simply on a dream she remembered from many years before but it was real and strong for her.

Mr B. started injections of Omnopon soon after admission and then changed to morphine. He never needed more than morphine gr ¼ three times in the 24 hours, and he continued to have his usual medicine regularly by mouth. His face was dressed with liquid paraffin.

After two months he was obviously going downhill but he remained alert nearly all the time. One episode of climbing out of bed at night was controlled with one injection of hyoscine and he never needed it again. One day he said to me "I am comfortable now but it has been such a lot and I am so tired and wish it were over." I told him that it would not be much longer that all would be well and how we admired his patience. He was grateful and seemed comforted. He died peacefully a few days later having slept quietly throughout the previous night. His wife visited him faithfully till the last day. Afterwards she wrote a letter thanking all of us for "helping to ease his pain and suffering." She added "He is now with the Lord in the heavens of rest and sleep. We have no more worry, he is happy." There was no word of bitterness or complaint. Her love had helped him to the end and her faith still stood in its complete simplicity.

A patient may go downhill imperceptibly and then quite suddenly an indefinable change occurs and we know that he is dying. Single rooms are a comfort when relations can stay longer and other patients need not be distressed but loneliness is sometimes terrifying for the dying and we must constantly be with them. Sometimes too it has helped others when patients have died

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in the ward to know that death itself was quiet and peaceful

Observant Care

Dying patients do not like to lie flat on their backs and they are unable to move themselves. They should be moved gently and frequently if they are restless. They need to be propped up so that their heads are well supported They are often afraid of the dark and need light and fresh air They hate imprisoning bed clothes and their restlessness is often an attempt to throw them off They may need sponging and rubbing as they often sweat profusely as their extremities gradually become cold and clammy Thirst is their last craving and sips of iced water regular cleaning of the mouth and salve to the cracked lips can still be comforts. The death rattle of noisy tracheal secretions can be stopped by an injection of atropine if it is given in time

The need for analgesics and hypnotics often decreases as death approaches but they should not be stopped abruptly nor till the patient sinks into deep unconsciousness. If they are withdrawn too soon patients may become restless and distressed

Even if a patient lingers in this stage and can make no flicker of recognition he may well know who is with him and find comfort in their presence Hearing is the last sense to go and we should tell the relations this and be very careful not to forget it ourselves.

Most patients are unconscious at the moment of death and some seem to drift into this state unaware of what is happening One sister who has cared for these patients for over 20 years tells me however that she is convinced that the great majority do know at the end and that they accept it peacefully I have known several who wanted to talk only a few hours before they died. They were not frightened nor unwilling to go for by then they were too far away to want to come back. They were conscious of leaving weakness and exhaustion rather than life and its

if it is only sitting up and holding a hand. Those with other responsibilities may have to be restrained from an over-lengthy watch but some find it easier to bear a parting when they know they were the last to say goodbye. Others cannot stand any more, especially if they are worn out with nursing at home beforehand. They need reassuring that they have done all they could, lest they should feel guilty. Indeed we must always be alert to sense this when relations come with a patient for admission and try to stop them adding to their own burdens by blaming themselves for failing those they love. Few people really evade their responsibilities even in these days and many go very much farther than the second mile.

Every ward sister will know that our work is not ended once the patient has died. This will be a very individual matter but time spent in listening to expressions of grief or in the telling of memories may be of great value in helping the relations to start on the path to normal living again. More practical help in the form of cups of tea and instruction about registration and other procedures are also essential in the first stunned moments.

It may be possible to call on the chaplain to help relations when a patient is dying. This can be the greatest help to everyone but even so relations may still look to the staff they know and whom they have seen caring for the patient's physical needs and they can derive much support from them.

The care of the dying should not be an individual work but one that is shared. Shared with the relations, with all the various members of the staff, spiritual, medical and lay and as far as we can, with the patient himself. Where this is so we are left with a sense of fulfilment which makes this such a rewarding branch of medical and nursing care.

[I would like to thank the staff and patients of the terminal hospitals in London for their inspiration and help.]